Health Care Finance Working Group: Costs and Premiums
Proposed Findings on Nursing Homes – Preliminary Draft of 7/24/00, noon

OVERVIEW

Long term care is composed of several types of providers and services, including home health care, assisted living arrangements, and nursing homes. This interim report is focused on the financial condition of nursing homes, but that focus should not be taken to mean that other components of long term care are less important. Those other components, as well as the continuum of services comprising long term care, will also be examined and analyzed in a subsequent report. In addition, other themes relating to nursing homes as well as other elements of the long term care continuum, such as quality of care and access to care, will also need to be considered.

This document is designed primarily to present the working group's findings with respect to the financial condition of nursing homes in Massachusetts and to outline broad policy options for responding.

Problems

The financial health of the Massachusetts nursing home industry as a whole is worsening. As a result, nursing homes in Massachusetts (with some exceptions) are generally much worse off financially then they were several years ago, and are generally worse off than nursing homes in neighboring states. [Figures 1 through 4] Attention has been drawn to nursing homes' financial condition by the numerous bankruptcies of national nursing home chains. Approximately 25% of the nursing home beds in the Commonwealth are owned or operated by corporations now in bankruptcy, including 14,000 beds owned by national corporations in bankruptcy. [Figures 5 through 8] In addition, many nursing homes have reported extreme difficulty in attracting and retaining qualified direct care staff in the current tight labor market [cite to Federation newsletters]. As a consequence of their high staff vacancy rates, these nursing homes report that they are increasingly dependent on temporary nursing pools, which charge rates that exceed the cost of directly employed staff, for staff assistance. The combination of nursing homes' stressed financial condition, their associated difficulty in paying attractive salaries, and the general shortage of direct care workers has begun to show in reports of deteriorating quality of care, according to the Department of Public Health. For the longer term, there is reason to worry that the rising number of people over age 85 will increase the demand for publicly funded long term care.

Causes

Massachusetts relies on nursing homes more than most other states, and more than the national average. [Figures 9 and 10] Currently, Massachusetts has approximately 550 nursing homes, 514 of which accept Medicaid patients, with a total of 55,000 beds. Industry-wide, the average occupancy rate is approximately 93%. [DHCFP] Compared with national averages, the nursing home population in Massachusetts has a lower, but growing level of care need or acuity level. [Figures 11 and 12]. Like hospitals, nursing homes have experienced a shift in payer mix that has left them with reduced revenue in relation to their costs:

- Through the 1980s, facilities relied on private payment to provide a margin on which they balanced their lower paying Medicaid business.[Figure 13 and 14]
- In the 1990s, many privately paying seniors chose alternative options such as assisted living communities and community based services.
- In part to compensate for the loss in private-pay patients, facilities increased their reliance on relatively generous Medicare payments for nursing home and ancillary services to generate offsetting margins, which entailed accepting residents with greater care needs. As a result, Massachusetts nursing homes were somewhat more dependent on Medicare than nursing homes nationally on average. [Figures 15 and 16]
- In the late 1990s, the beneficial Medicare margin disappeared with the implementation of the nursing home provisions of the BBA. [See GAO report]
- Thus most facilities have become increasingly dependent on Medicaid as their major source of financing.
- Historically, Medicaid payment policies have been designed to cover the cost of care at a reasonably efficiently operated facility and therefore in most cases have not yielded a "cushion" sufficient to subsidize changes in conditions.

Other causes contributing to the weakening financial condition of the Commonwealth's nursing homes include:

- Declining availability of direct care workers, and rapidly rising labor costs as facilities struggle to retain workers and increasingly rely on temporary nursing agencies to supply direct care workers (caused by both the strong economy and weak nursing home financial condition).
- Substantial increases in debt service costs and profit requirements as a result of large-scale borrowing by chains to finance acquisitions of existing facilities, as well as increases in administrative cost structure relating to chains' size and corporate structure. [Figures 17 and 18. See also U.S. General Accounting Office report GAO/HEHS-00-23, Skilled Nursing Facilities: Medicare Payment Changes Require Provider Adjustments But Maintain Access, December, 1999]
- Excess capacity that was created to care for more intensive patients discharged "quicker and sicker" from hospitals, particularly patients covered by Medicare. [Figure 19]

OPTIONS

<u>Option I: Let the situation play out.</u>

The financial condition of nursing homes is serious, and there is no reason to expect improvement soon. Thus, it is likely that some facilities will close. Even where facilities do not close, the potential for quality of care to deteriorate due to financial pressures and extreme difficulty in attracting and retaining staff is very real and is a cause for concern.

While alternative care settings are available in many locations and more are being developed, many of those alternative care settings are not available to Medicaid clients. For example, Medicaid does not pay for assisted living arrangements and generally is not permitted under federal rules to pay for room and board in community settings. Therefore, people without private resources could have trouble accessing appropriate care in some circumstances.

The seriousness of the situation is heightened by the fact that approximately 25% of the Commonwealth's nursing home beds are in bankruptcy, due principally to the bankruptcies of large, multi-state chains. While most of these facilities are currently still in operation, it is difficult to forecast what will happen in the future, absent intervention. We can speculate about possible scenarios.

One possibility is that facilities now in bankruptcy could be bought at bargain prices by nonprofit owners, and lenders that financed expansion plans for the chains will be left with reduced or no compensation. Operation of the facilities could continue relatively unscathed under this scenario without changes in Medicaid payment policies or levels. Some believe that because nonprofit owners do not have to devote resources to shareholders, they would put a greater percentage of revenue toward direct care, with the result that care would be better. Others argue that such nonprofits would ultimately generate high operating costs, and they too would need increased revenues to continue operating.

Another possibility is that creditors may demand payment in a way that compromises facilities' ability to deliver adequate care. For example, if facilities are obligated as a condition of coming out of bankruptcy to pay more to creditors than they do under their current bankruptcy protection, they may be left with fewer resources to devote to staff. As a consequence, they may have even more difficulty attracting and retaining staff, with the result that quality of care worsens. Under that scenario, we could see widespread and rapid closures or need for receivership.

Option II: The state could "bail out" the nursing home industry

Under this approach the State would infuse a great amount of resources across the board into the ailing nursing home industry through increased Medicaid payments. The goal under this approach would be to make individual facilities "whole" – to restore them to financial health. Note that this approach could not "make whole" the bankrupt national chains that own and operate large numbers of facilities in Massachusetts. Furthermore, to the extent that local facilities are required to pass on increased reimbursements to their parent companies and then to their creditors, these increased payments might not even make local facilities "whole." Because of these limitations, a "bail out" approach would not guarantee that local facilities would not close or that quality would improve.

This approach would entail several significant consequences. First, the magnitude of the investment it would require is significant. Medicaid currently spends approximately $1.2 billion per year on nursing home care in Massachusetts. [DMA] For example, to increase rates across the board by just 2% would cost approximately $26-30 million. [DHCFP] Many facilities would argue that a far greater increase would be required to enable homes to operate well.

Moreover, this approach would entail departing from the Commonwealth's policy of paying Medicaid providers according to formulae designed to encourage efficient provider operations and provision of services. This payment policy was intended to move away from the previous system that paid providers based on their historical costs, with the result that they had no incentive to lower costs. [See attached summary of Massachusetts Medicaid Skilled Nursing Facility Payment Methodology 1995-2000.] Under a "bail out" approach, payments would again be designed to cover costs.

Finally, under this approach the Medicaid program would, in effect, assume the burden of paying for the changes in circumstance that led to the current financial condition of nursing homes. These changes include reductions in Medicare payment, reductions in private-pay residents, difficulty attracting and retaining staff, and in some cases, financial burdens resulting from corporate expansion strategies. Mean Medicaid rates have risen faster than health care costs nationally over the last five years. [Figure 20] Increasing rates by a significantly greater percentage would (a) have immediate fiscal consequences for the Commonwealth given the size of this program, and (b) entail a departure from the philosophy that Medicaid should not subsidize costs or losses unrelated to direct care of Medicaid enrollees.

Option III: The state could implement a short term plan to support the nursing home industry and provide targeted assistance while evaluating broader long term care policy.

The goal under this approach would be to support the industry over a short period of time (e.g., two years), while also engaging in a longer term planning process to address structural problems in long term care, including nursing home care.

Short term support could be accomplished through some combination of several elements, for example: (1) reasonable Medicaid rate increases, with a focus on wages for direct care staff; (2) a stabilization plan including increased capacity to monitor quality of care and to intervene if necessary where quality has deteriorated; (3) special targeted assistance – loans, grants or technical assistance – where necessary; (4) use of receivership where necessary (it has also been suggested that the state consider, as a last resort, purchasing nursing homes in receivership or bankruptcy and contracting for management by a private operator); and (5) creative approaches to staffing issues, such as changes in licensing requirements and recognition of alternative licenses (e.g., from other states). Creative proposals for structuring such intervention and support in ways that are permissible under existing law and regulation should be encouraged and could be tried on a pilot basis as necessary. Examples of such creative approaches currently being developed include helping nursing homes to develop care and living models more closely resembling assisted living models, which are more attractive to privately paying seniors, possibly with state loan assistance.

Legal barriers to intervention on a selective basis should be explored and consideration should be given to whether those barriers should be modified or changed where possible.

Stabilization efforts would be coordinated with intermediate and long range planning for long term care, including an assessment of the Commonwealth's projected need for nursing home beds in the future and an assessment of current access to nursing home care.

This approach would require contingency planning. For example, if widespread deterioration in quality were to occur, the Department of Public Health and the Attorney General could be called upon to take large numbers of homes into receivership or to require operational changes that bolster quality of care. [reference to attachment summarizing receivership law] Also, if large numbers of nursing homes were to close, the Commonwealth would need to ensure the safe relocation of large numbers of residents. Such relocations can be traumatic for nursing home residents and should be avoided where possible. The Commonwealth should engage in planning for such contingencies.

Recommendation

The Group rejects Option I, "Let the Situation Play Out." As discussed above, the Group is convinced that the current financial trends in the nursing home industry are such that unless there is some form of State intervention, the financial conditions of the industry as a whole will not substantially improve and that several homes will likely close. We are equally concerned that for some of the homes that remain open, their negative financial situation could lead to a deterioration in the quality of patient care.
We will discuss below what type of State intervention we prefer recognizing that at least some of the nursing home industry's financial woes are due to poor business decisions as evidenced by the large debt accumulated by some national chains in their quest to expand ownership of more facilities. We also recognize that a number of other factors have contributed to the current financial condition of the industry, including reductions in Medicare revenue, declining census of private patients and a severe labor shortage attendant to the robust economy. Some would also argue that low Medicaid payments and the change in its payment methodology have added to the problem. Regardless of the appropriateness of Medicaid payment policies the fact remains that on average, nursing homes depend on Medicaid to pay for the care of over 70% of their residents. While Medicaid may not be "the solution" to all the current financial problems of nursing home, it is clear, given its responsibility for such a large percentage of nursing home residents, that Medicaid must play an important part in resolving what appears to be an unstable situation.

The Group also rejects Option II, "bail out the nursing home industry." There is wide variation in terms of financial health of facilities, facility cost, rate of occupancy, and access to nursing home beds throughout the state. A systemwide "fix" would fail to take into account these variations, and would in some instances reward bad management practices. At the same time it would fail to reward good management practices, such as keeping operating costs low. In short, this approach would effectively negate the joint efforts of both the industry and the state to develop a rate methodology that is designed to provide incentives for efficient operation, low cost and high quality care. Moreover, it would involve the state's assumption of the "bill" associated with circumstances beyond the state's control, such as changes in Medicare payment policies. Finally, because of the magnitude of the investment that would be required, this approach would (realistically) severely limit the resources that could be devoted to other components of the long term care continuum, including the development of more community-based arrangements – for which consumers have expressed preference.

The Group recommends Option III: Support and Targeted Assistance for the Nursing Home Industry, while broader long term care planning is pursued. This will require the Commonwealth's commitment to targeted increased funding as well as to comprehensive planning. Short term stabilization efforts should be further developed by or coordinated with agencies working on Executive Order 421 (issued earlier this year by Governor Cellucci, directing agencies to develop a plan for long term care over the next five years) and with the Vision 20/20 group organized by Health Care Committee Co-Chairman Harriette Chandler to engage in longer-range planning for long term care needs, to ensure the following:

1. Focus on staffing, including function, availability, retention, licensing and professional development (such as the wage pass-through included in the proposed FY 2001 budget).
2. Ensuring additional state resources are tied to quality outcomes.

3. Auditing nursing home expenditures to ensure that funds are not used to pay creditors or excessive administrative costs.
4. Measuring and reporting geographic access to nursing homes and other long term care options.
5. Developing strategies to increase local (in-state) control of nursing facilities.

Longer term policy development should include consideration of the following:

While the Commonwealth's responsibility to ensure quality of care for nursing home residents is paramount, increased investment in nursing facilities by the Commonwealth should ideally be balanced with other important public policy goals for long term care and health care generally. This kind of balancing entails a more active health planning operation than has been maintained in government over the last decade. Some objectives of planning could be to project numbers of people in need of publicly-financed long term care and likely need for nursing home beds and non-nursing home services over the short and long term, financial tracking of nursing homes and home care providers, regular monitoring of health care worker availability, and monitoring of the relationship between long term care and acute care needs and utilization. In addition, such planning could support the development of creative alternative models of supported living, such as cooperative living and care-giving models in the community.

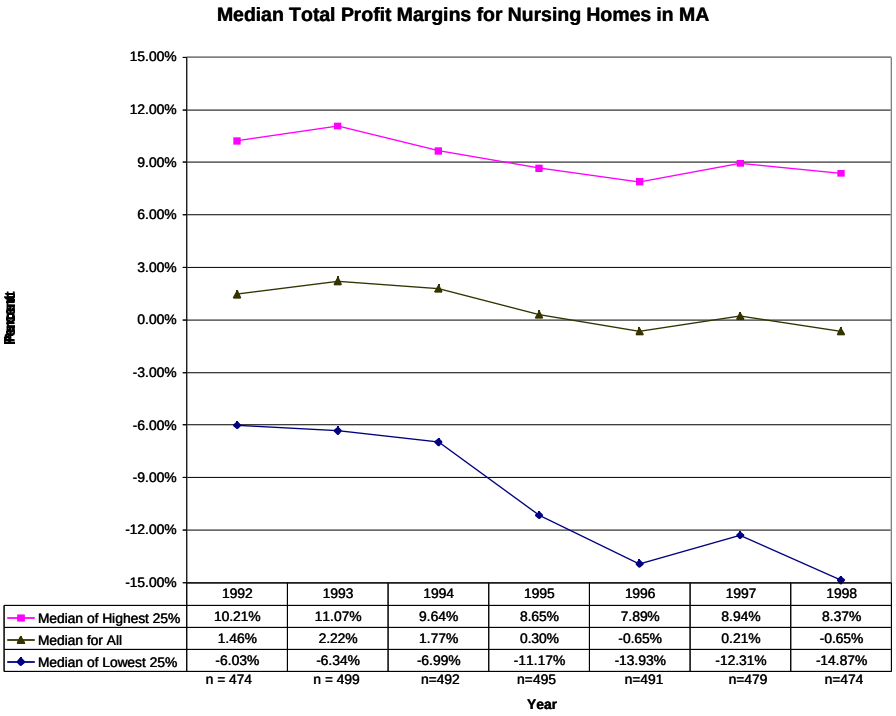
Planning efforts should also take into account developing legal interpretations of states' obligations under the Americans with Disabilities Act with respect to development of community-based long term care, and should be part of more coordinated policy development in related areas, such as general home health care and housing policy.

The state should explore ways of paying for non-medical care in coordination with medical care provided in the community setting in order to balance the preservation of nursing home capacity with the development of community-based alternatives. In states where the payer mix among providers in various parts of the long term care continuum is more balanced, providers appear to be more financially stable. Efforts to change payer mix in nursing facilities and to increase access to community-based services have been tried before, and we must continue to be creative in developing new approaches for both short term and long term strategies, possibly developing various approaches through pilot programs.

Given the stated preference of most people to receive long term care in the community rather than in a nursing home, the state should study effective ways of promoting access to community-based services. Still, for those who require the most intensive care, nursing homes offer the most efficient setting.

There are a number of dilemmas inherent in trying to plan for the Commonwealth's long term care needs while also trying to address current problems. The overwhelming majority of state funding for long term care is devoted to nursing homes, yet the overwhelming majority of people needing long term care prefer to remain in the community. And, even though the overwhelming majority of state funding has been devoted to nursing homes, their financial stability and quality of care have been threatened in recent months. Ensuring that safe and adequate long term care options will be available for the growing numbers of people who will need that care in the coming years presents significant challenges.

Figure 1:

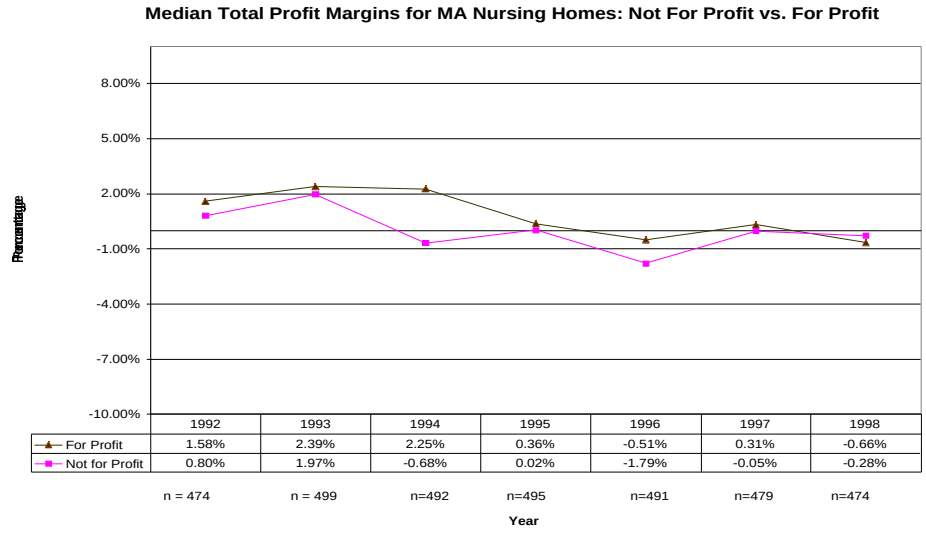


	1992	1993	1994	1995	1996	1997	1998
Median of Highest 25%	10.21%	11.07%	9.64%	8.65%	7.89%	8.94%	8.37%
Median for All	1.46%	2.22%	1.77%	0.30%	-0.65%	0.21%	-0.65%
Median of Lowest 25%	-6.03%	-6.34%	-6.99%	-11.17%	-13.93%	-12.31%	-14.87%
	n = 474	n = 499	n=492	n=495	n=491	n=479	n=474

Source: Massachusetts Division of Health Care Finance and Policy Nursing Home Cost Reports
Facilities in each year are only those that were open the whole year.

- This graph shows that profit margins for most of the industry have declined slightly in recent years, compared to the early 90's, but that the worst off facilities have perilously poor margins.
- The top line is the median margin for the best off 25% of facilities, the middle line is the median of all facilities, and the bottom line is the median for the worst off 25%.
- Total Profit margin = (total revenues – total expenses) / total revenues

Figure 2:

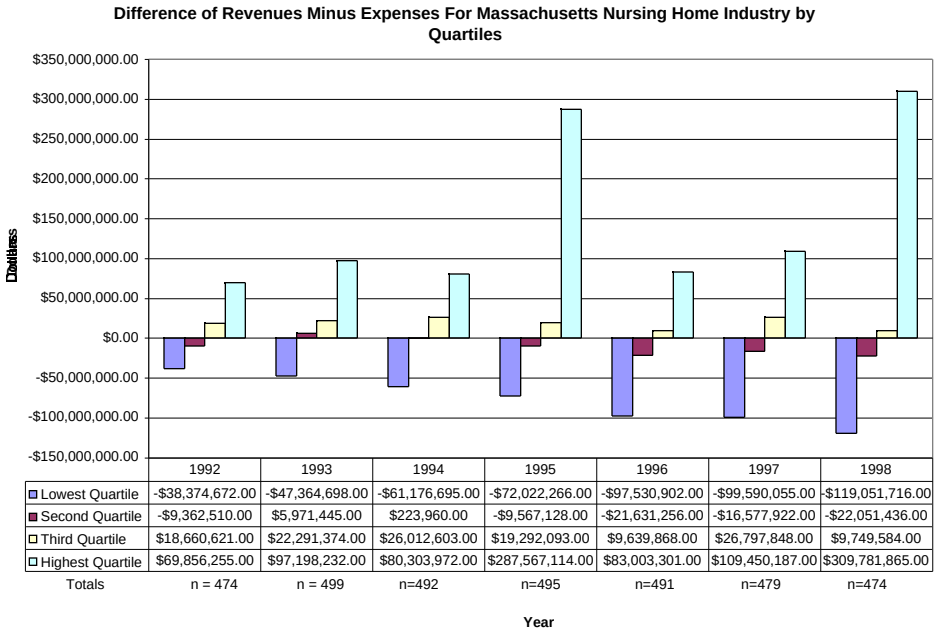


	1992	1993	1994	1995	1996	1997	1998
For Profit	1.58%	2.39%	2.25%	0.36%	-0.51%	0.31%	-0.66%
Not for Profit	0.80%	1.97%	-0.68%	0.02%	-1.79%	-0.05%	-0.28%
	n = 474	n = 499	n=492	n=495	n=491	n=479	n=474

Source: Massachusetts Division of Health Care Finance and Policy Nursing Home Cost Reports
Facilities in each year are only those that were open the whole year.

- On average, for profit facilities were more profitable than not for profit facilities for most of the 90's, but were less profitable in 1998.

Figure 3a:

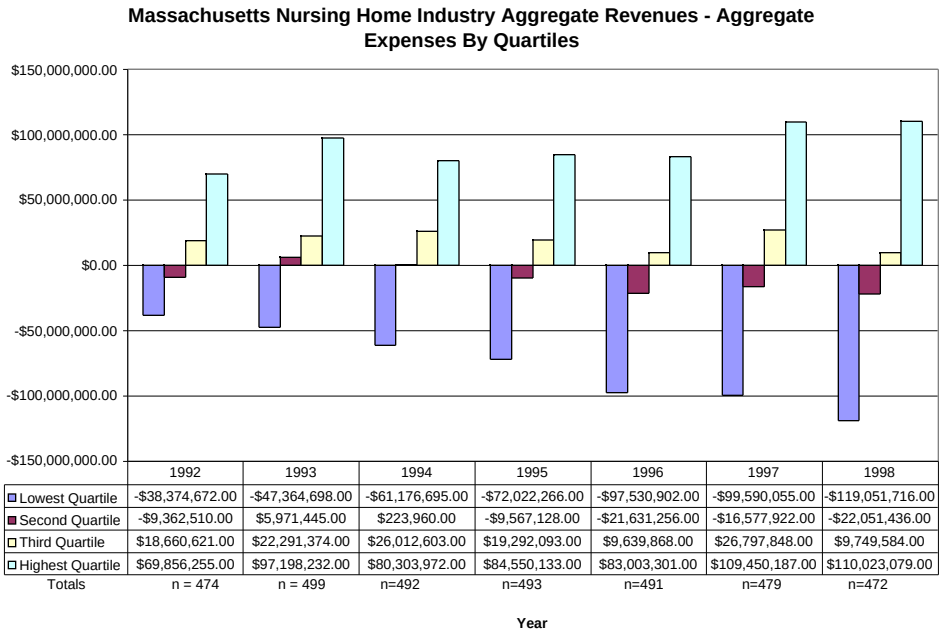


	1992	1993	1994	1995	1996	1997	1998
Lowest Quartile	-$38,374,672.00	-$47,364,698.00	-$61,176,695.00	-$72,022,266.00	-$97,530,902.00	-$99,590,055.00	-$119,051,716.00
Second Quartile	-$9,362,510.00	$5,971,445.00	$223,960.00	-$9,567,128.00	-$21,631,256.00	-$16,577,922.00	-$22,051,436.00
Third Quartile	$18,660,621.00	$22,291,374.00	$26,012,603.00	$19,292,093.00	$9,639,868.00	$26,797,848.00	$9,749,584.00
Highest Quartile	$69,856,255.00	$97,198,232.00	$80,303,972.00	$287,567,114.00	$83,003,301.00	$109,450,187.00	$309,781,865.00
Totals	n = 474	n = 499	n=492	n=495	n=491	n=479	n=474

Source: Massachusetts Division of Health Care Finance and Policy

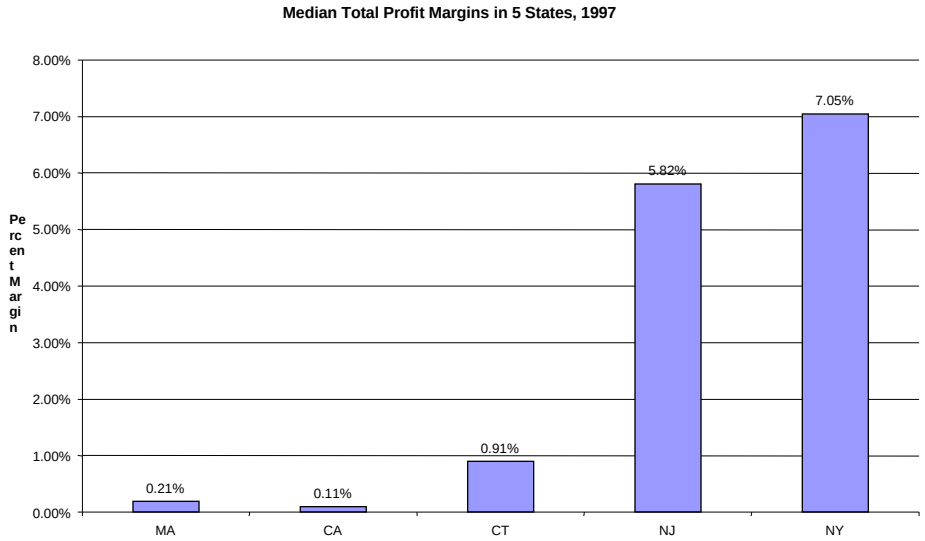
- The above graph represents, by quartiles, aggregate total revenues – aggregate total expenses for the nursing home industry in Massachusetts.
- The quartiles were created based on total profit margin, so the lowest quarter in this graph are the same facilities represented in the lowest 25% in Figure 2.
- The unusual increase in 1995 among the highest quartile was due to exceptionally high numbers at two facilities, most probably due to a sizeable financial transaction. Similarly, the increase in 1998 was also due to high values at two facilities for which 1998 was the first full year of operation.
- The structure of the cost reports does not allow for the differentiation between operating and non-operating expenses; hence values for the total margin have been used for comparison.

Figure 3b: (Data from Figure 2a, minus 2 outliers each from 1995 and 1998)



	1992	1993	1994	1995	1996	1997	1998
Lowest Quartile	-$38,374,672.00	-$47,364,698.00	-$61,176,695.00	-$72,022,266.00	-$97,530,902.00	-$99,590,055.00	-$119,051,716.00
Second Quartile	-$9,362,510.00	$5,971,445.00	$223,960.00	-$9,567,128.00	-$21,631,256.00	-$16,577,922.00	-$22,051,436.00
Third Quartile	$18,660,621.00	$22,291,374.00	$26,012,603.00	$19,292,093.00	$9,639,868.00	$26,797,848.00	$9,749,584.00
Highest Quartile	$69,856,255.00	$97,198,232.00	$80,303,972.00	$84,550,133.00	$83,003,301.00	$109,450,187.00	$110,023,079.00
Totals	n = 474	n = 499	n=492	n=493	n=491	n=479	n=472

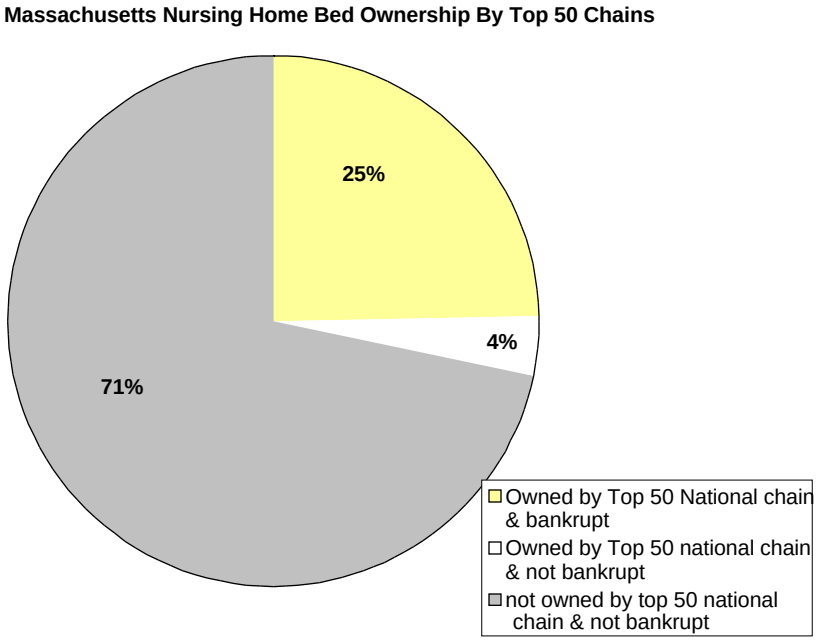
Figure 4:



Source: Massachusetts data from Massachusetts Division of Health Care Finance and Policy
Other states' data from *Guide to the Nursing Home Industry*, HCIA 2000

· Average profit margins for Massachusetts facilities are lower than in other states.

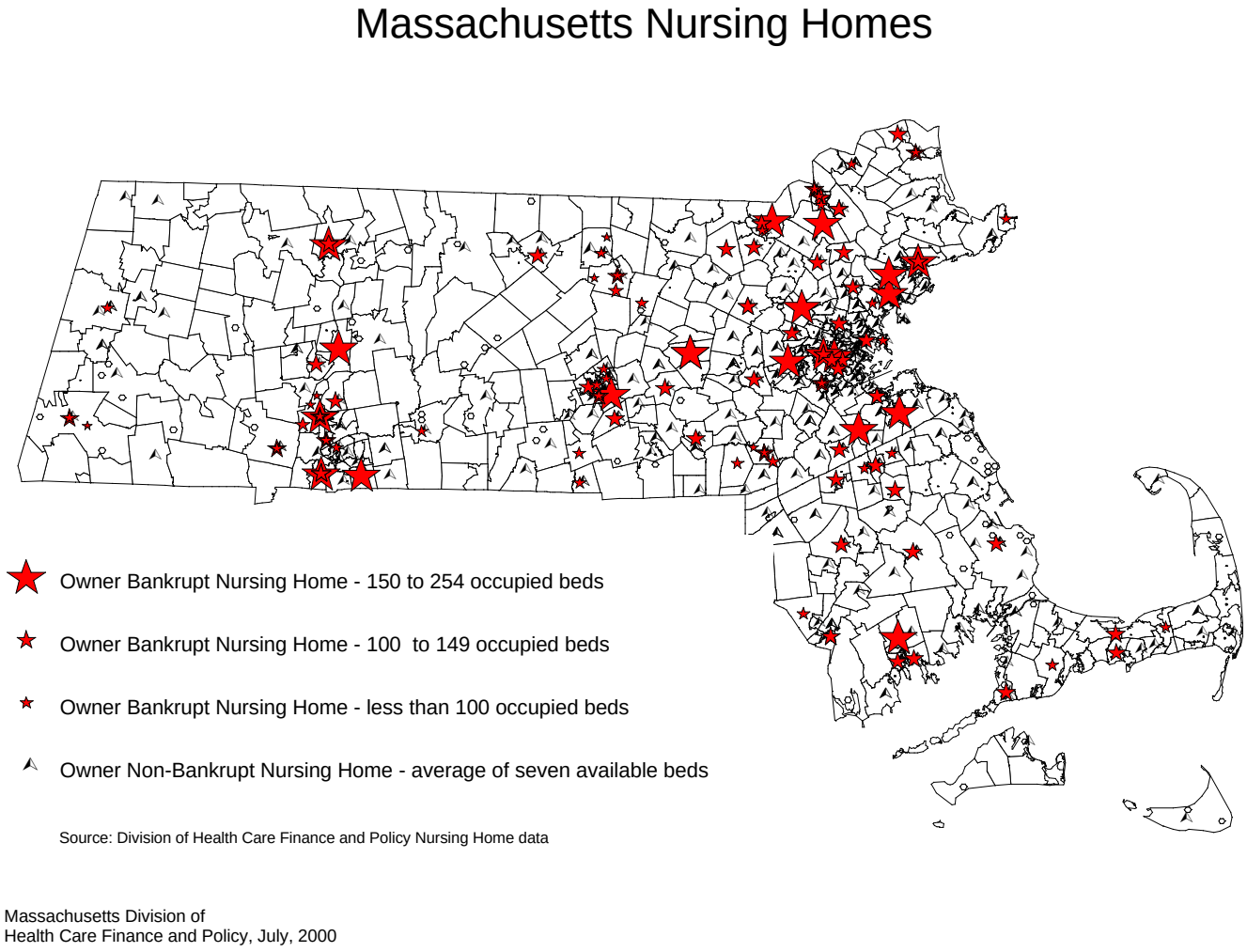
Figure 5:



Sources: Massachusetts Division of Health Care Finance and Policy
Top 50 Chains from Modern Healthcare [add date/volume]

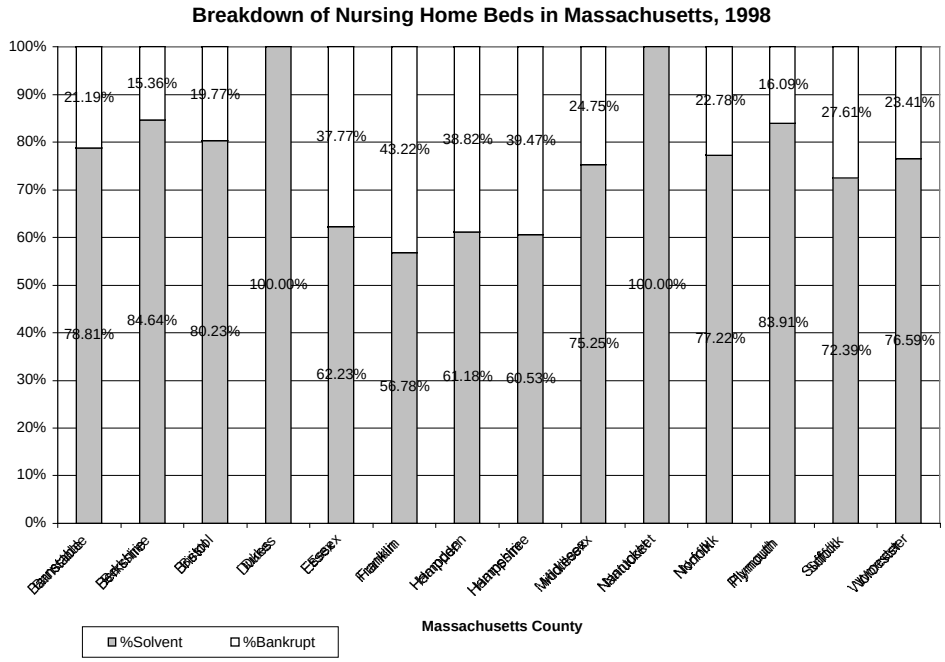
· 29% of nursing facility beds in Massachusetts are owned by one of the nation's 50 largest nursing home chains, measured by total revenues. A number of the largest chains have filed for bankruptcy, with the result that 25% of nursing facility beds in Massachusetts are owned by bankrupt corporations.
· Beds are FY 98 data based on current bankruptcy status.

Figure 6:



· The concentration of beds that are owned by bankrupt firms in certain areas, such as Lawrence, Lowell, New Bedford, and Greenfield overwhelm the availability of vacant beds in those areas.

Figure 7:



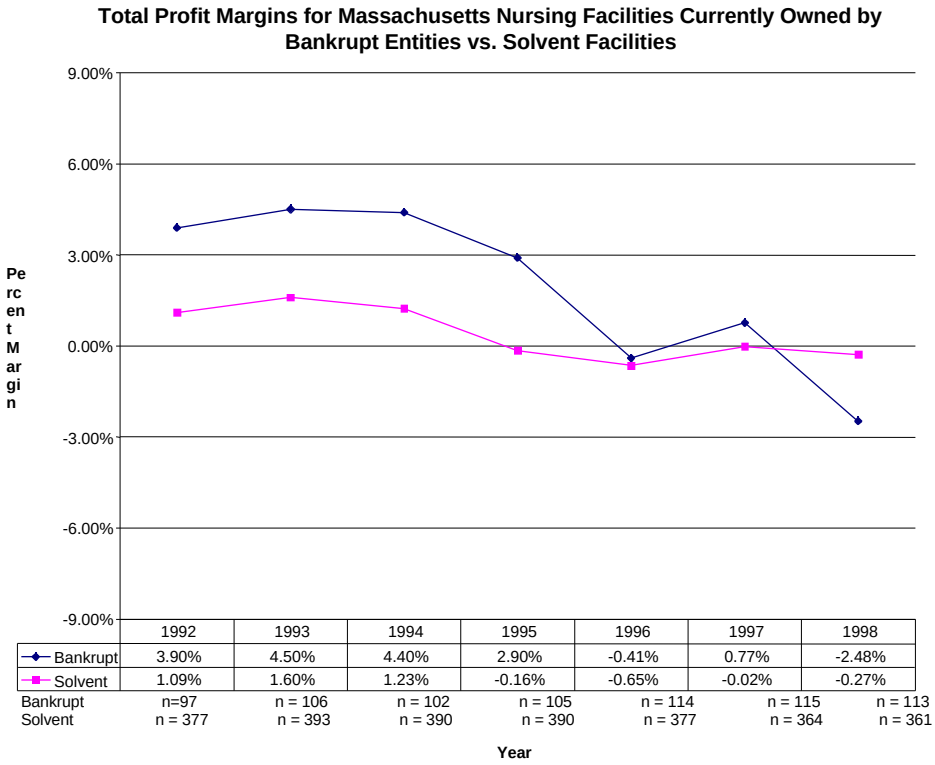
Source: Division of Health Care Finance and Policy

- Bankrupt firms own over 40% of skilled nursing beds in Franklin County; and over 35% of beds in Essex, Hampden and Hampshire Counties. Bankrupt firms own 15-27% of beds in all other counties except Dukes and Nantucket.
- There are more than 10 times more skilled nursing beds owned by bankrupt firms than there are beds available to accept patients from those facilities if they should they close.

County	Total Beds	Beds Owned by Bankrupt Chains	% Bankrupt	Available Beds: Vacant and Owner not in Bankruptcy	% Available Non Bankrupt Beds
Barnstable	2,265	480	21%	57	3%
Berkshire	1,745	268	15%	31	2%
Bristol	4,734	936	20%	74	2%
Dukes	27	-	0%	-	0%
Essex	6,417	2,424	38%	149	2%
Franklin	701	303	43%	50	7%
Hampden	4,438	1,723	39%	124	3%
Hampshire	978	386	39%	16	2%
Middlesex	10,201	2,525	25%	164	2%
Nantucket	45	-	0%	-	0%
Norfolk	6,180	1,408	23%	167	3%
Plymouth	4,140	666	16%	83	2%
Suffolk	5,190	1,433	28%	148	3%
Worcester	7,391	1,730	23%	145	2%
TOTAL	**54,535**	**14,281**	**26%**	**1,208**	**2%**

Source: DHCFP FY 98 SNF cost reports. 514 facilities included in database, 124 of which are owned by national chains currently in bankruptcy.

Figure 8:

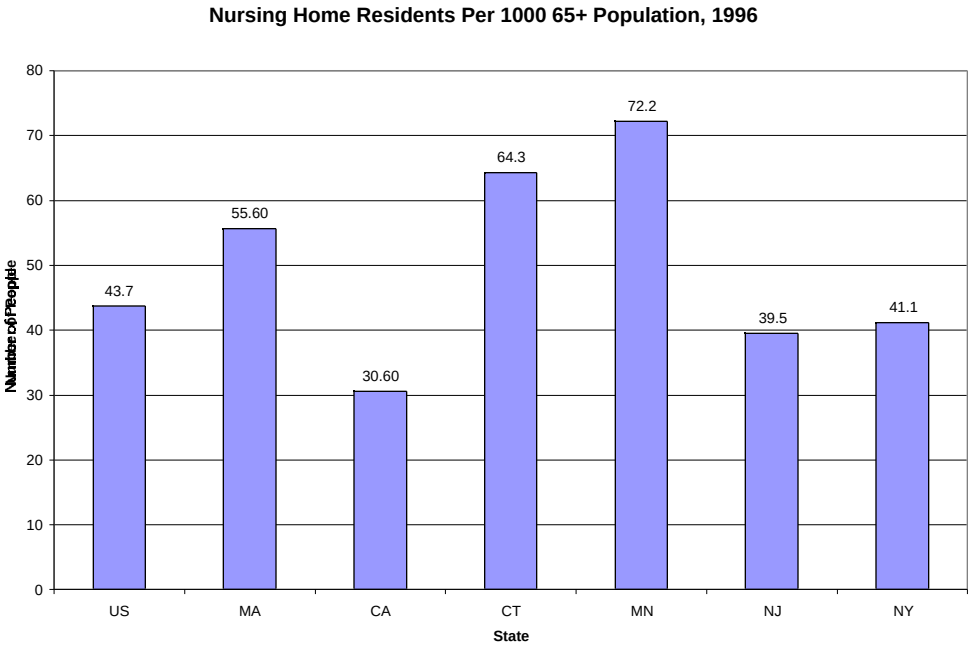


	1992	1993	1994	1995	1996	1997	1998
Bankrupt	3.90%	4.50%	4.40%	2.90%	-0.41%	0.77%	-2.48%
Solvent	1.09%	1.60%	1.23%	-0.16%	-0.65%	-0.02%	-0.27%
Bankrupt	n=97	n = 106	n = 102	n = 105	n = 114	n = 115	n = 113
Solvent	n = 377	n = 393	n = 390	n = 390	n = 377	n = 364	n = 361

Source: Massachusetts Division of Health Care Finance and Policy

- The above graph compares the median total profit margins for those facilities that today are owned by bankrupt entities to the median total profit margins of the facilities that have remained solvent.
- The bankrupt facilities had higher profit margins in 1992, but then followed a similar downward trend to the other facilities until 1996. Margins for all homes increased slightly in 1997, but then margins for the bankrupt homes declined sharply.
- Total Profit Margins were traced by facility, not ownership.
- All but 7 of the facilities that eventually went bankrupt changed ownership during the years 1992-1998. The n values in each year indicate how many facilities in each category were open for the entire year.

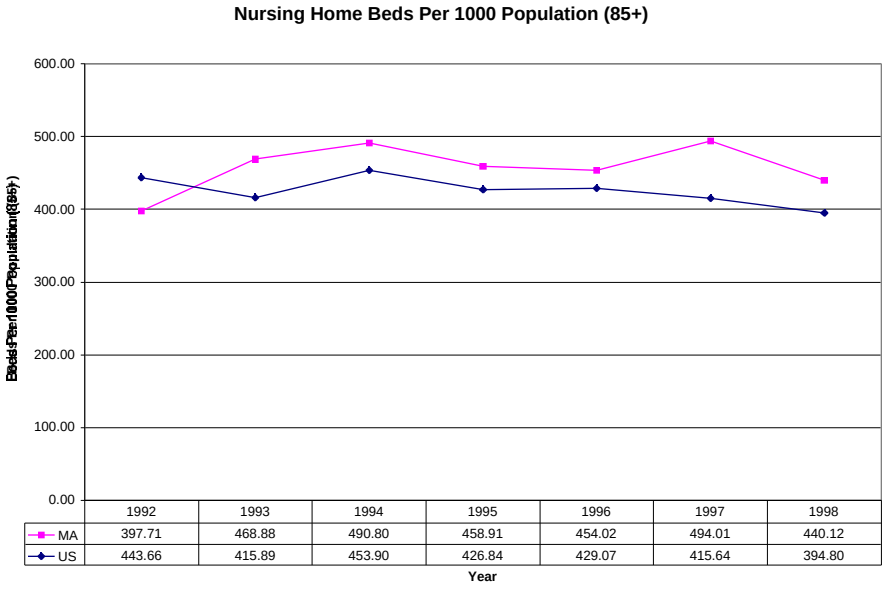
Figure 9:



Source: Across the States, 1998: Profiles of Long-Term Care Systems, *AARP 1998*

· Massachusetts residents use nursing homes at a higher rate than the national average, but at a lower rate than some other states, such as Connecticut and Minnesota.

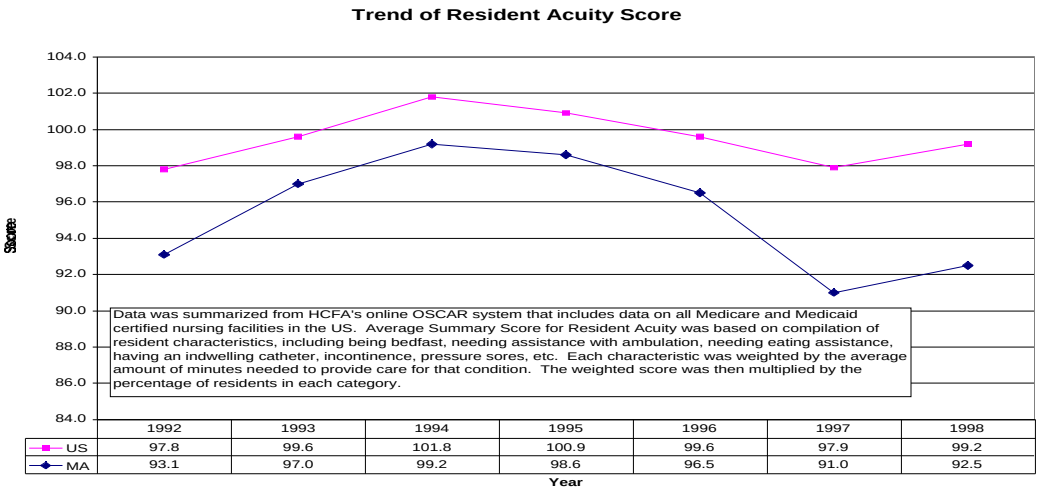
Figure 10:



Source: *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, '92-'98*, UCSF, 2000
Prepared for US Health Care Financing Administration

· Massachusetts has more nursing home beds than the national average, even when adjusted for our older population.

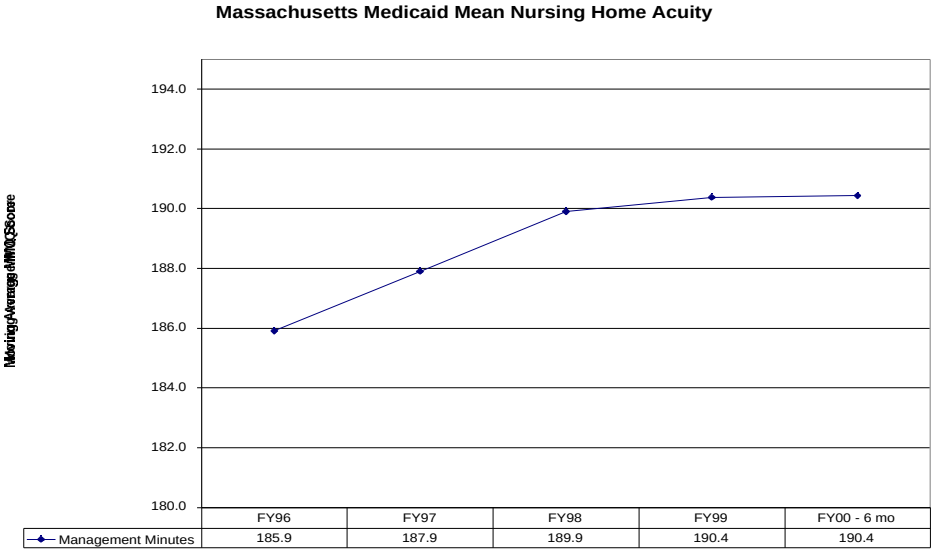
Figure 11:



Source: *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, '92-'98*, UCSF, 2000
Prepared for US Health Care Financing Administration

- Massachusetts nursing facility residents have less need, on average, for physical assistance, than residents nationally. This index measures the amount of care that this data indicates would need to be provided to each patient. This dataset is based on a survey administered to a sample population once per year.
- This data includes both Medicare and Medicaid patients. This data suggests that while the number of Medicare residents increased, their average dependence decreased.

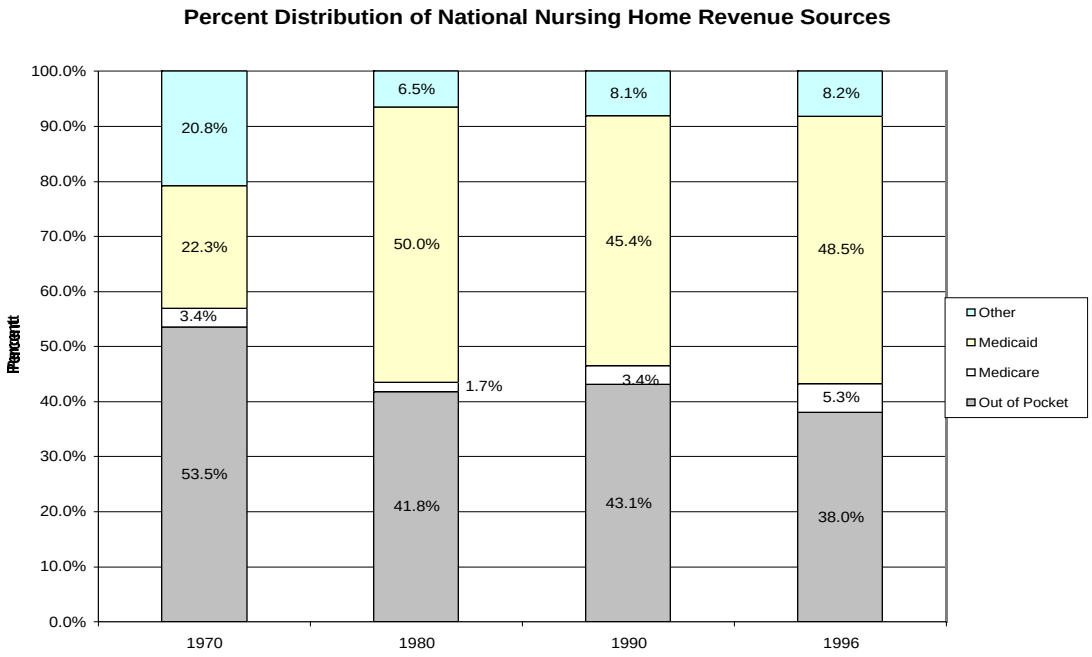
Figure 12:



Source:Massachusetts Division of Health Care Finance and Policy

- Data from the Massachusetts Medicaid program indicates that the acuity level of patients paid for by that program have been increasing.
- MMQ = Management Minutes Questionnaire, a measure of the number of minutes of care actually provided to each individual patient.

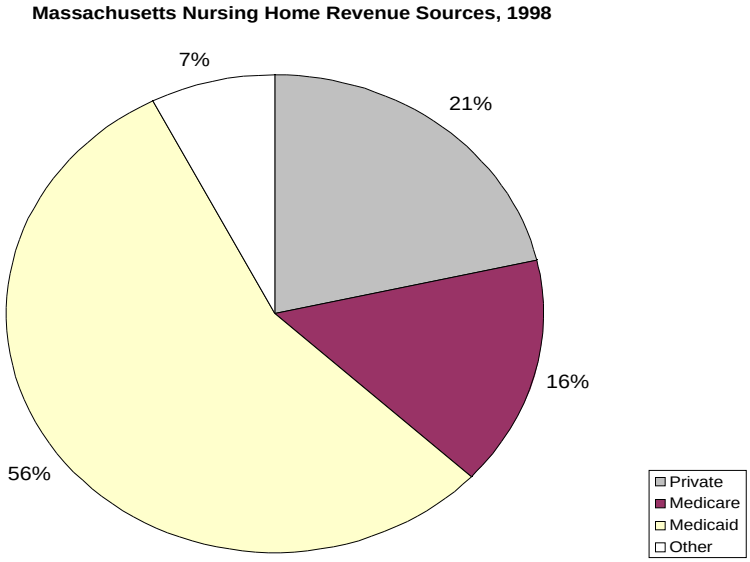
Figure 13:



Source: US Health Care Financing Administration

- From 1970 to 1980 the amount of nursing facility care paid for out-of-pocket, or from other private sources such as foundations and charitable organizations, declined dramatically; Medicaid picked up the difference. Medicare's share of nursing facility revenues is still small, but tripled from 1980 to 1996.

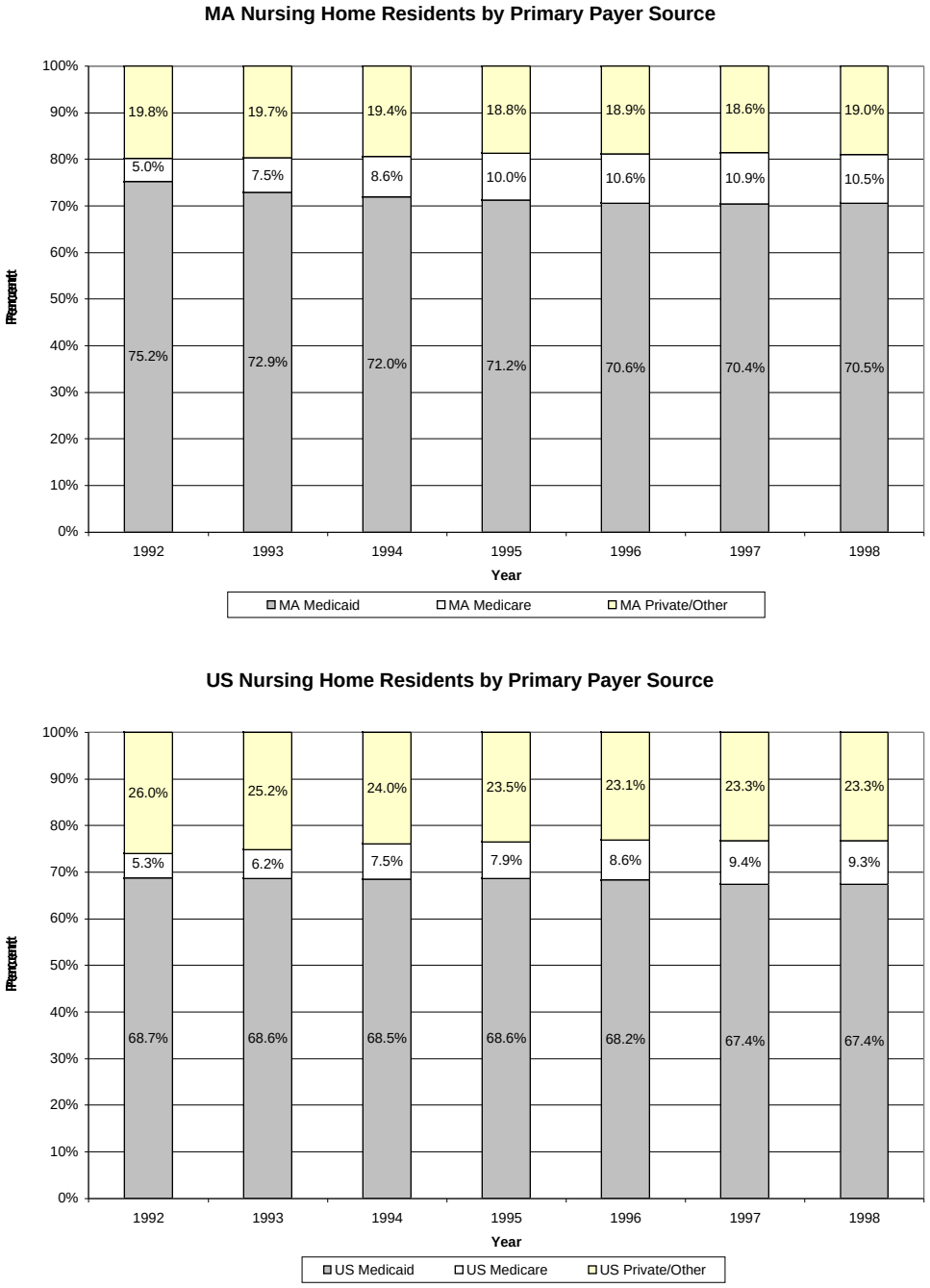
Figure 14:



Source: Massachusetts Division of Health Care Finance and Policy

- Among Massachusetts facilities that accept Medicaid, Medicaid provides a greater proportion of revenues than the national average, and Medicare and private payers provide a greater share.
- Medicare and private payers may provide a much larger share of revenues to the fewer than 50 Massachusetts facilities that do not accept Medicaid.

Figure 15:

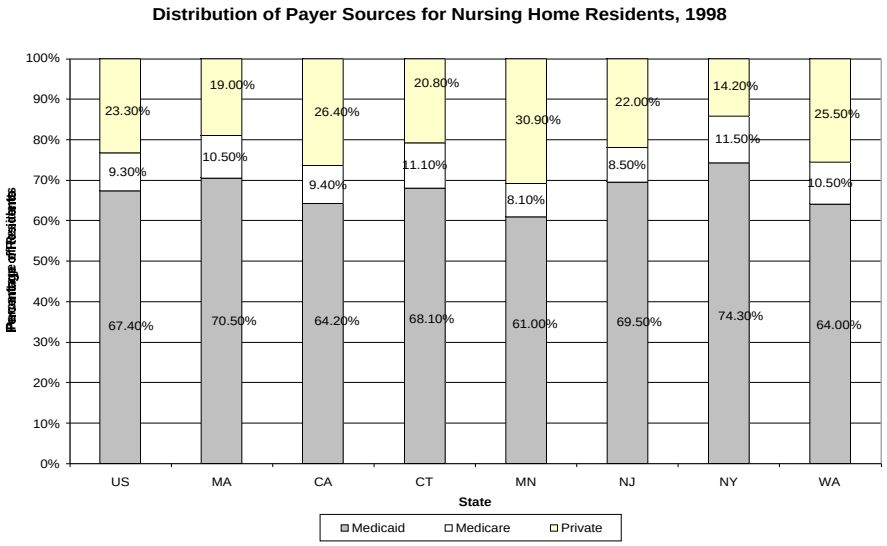


Source: *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, '92-'98*, UCSF, 2000
Prepared for US Health Care Financing Administration

- Compared to the national average, Massachusetts nursing facilities have fewer private patients, and more Medicare and Medicaid patients.
- For both Massachusetts and the U.S. the proportion of private patients has generally decreased during the 90's while the Medicare proportion has increased.
- The proportion of Medicare patients increased more in Massachusetts than nationally. At the same time, the proportion Medicaid patients decreased more in Massachusetts than nationally.
- The proportion of residents is so different from the proportion of revenues in Figure 12 because private and Medicare revenues per resident are much higher than Medicaid revenues per resident,

largely because of the much more intensive rehabilitation services required for Medicare and private patients.

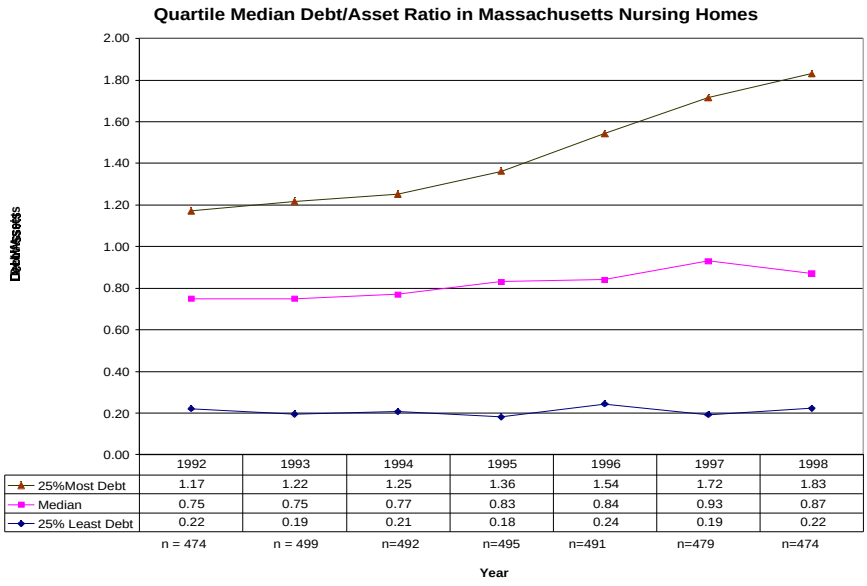
Figure 16:



Source: *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, '92-'98*, UCSF, 2000
Prepared for US Health Care Financing Administration

· Average payer mix for nursing facilities varies across states. Massachusetts facilities receive a smaller share of revenues from private payers than the national average, but more than New York. Medicare and Medicaid pay for a greater share of nursing facility care in Massachusetts than the national average, but less than in New York.

Figure 17:

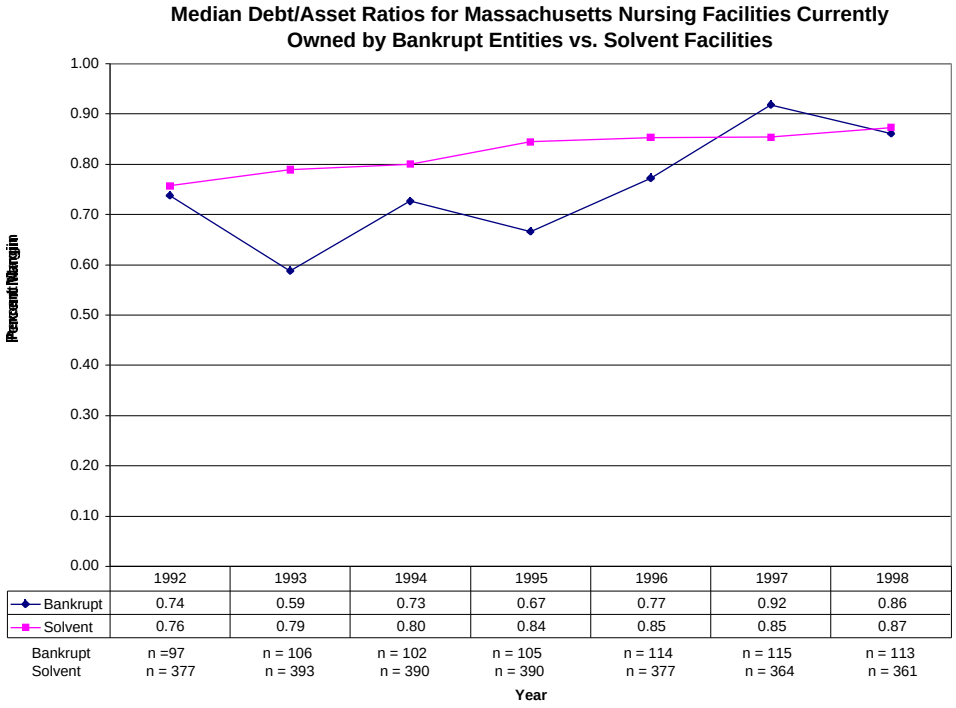


Source: Massachusetts Division of Health Care Finance and Policy
Facilities in each year are only those that were open the whole year

· The level of debt incurred by the facilities with the highest level of debt increased dramatically in recent years, while the median level of debt increased only slightly.

· The top line represents the median debt to asset ratio for the 25% of facilities with the highest ratios, the middle line represents the median for all facilities, and the bottom line is the median for the 25% of facilities with the lowest ratios.

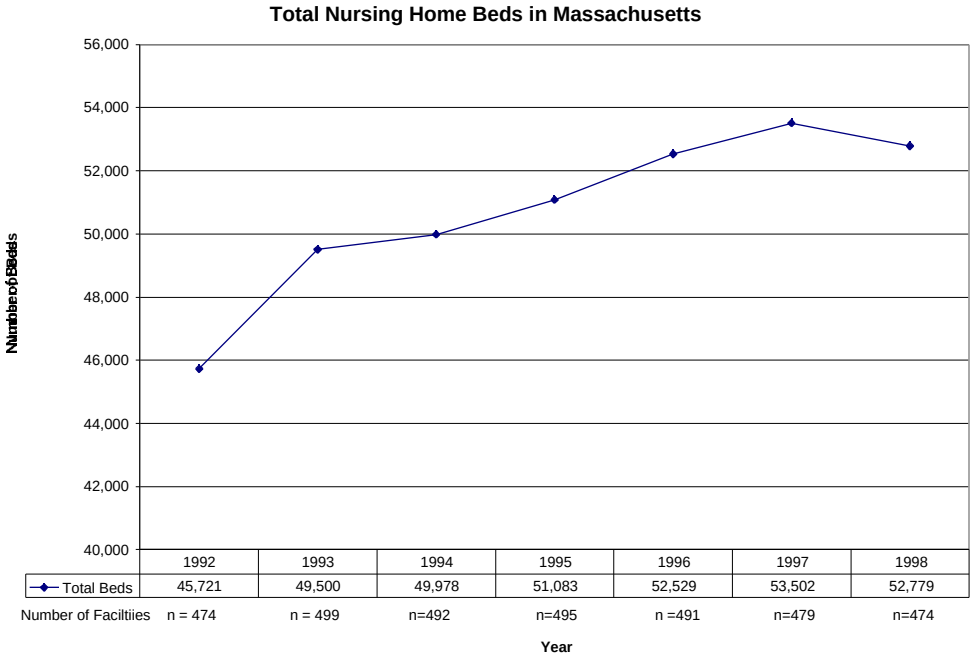
Figure 18:



Source: Massachusetts Division of Health Care Finance and Policy
Facilities in years 1992 –1997 include only those that were open the entire year.

· Median debt/asset ratios remained below the median for other facilities until 1997. Between 1995 and 1997, debt/asset ratios for bankrupt facilities increased faster than other facilities, but after 1997, the ratios for bankrupt facilities began decreasing again.

Figure 19:



Source: Massachusetts Division of Health Care Finance and Policy

· The total number of nursing facility beds in Massachusetts has increased significantly in recent years.

Figure 20:

Nursing Facilities
Per Day Medicaid Rates
Rates are adjusted to reflect the facility's annual casemix

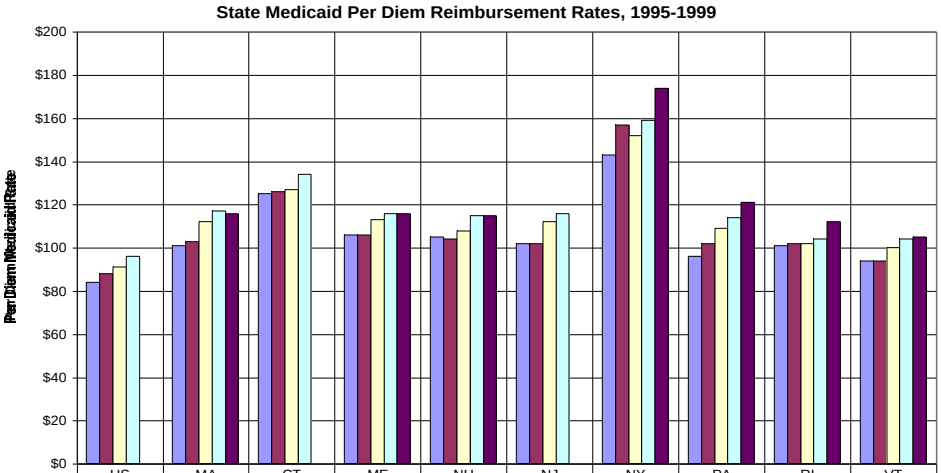
Year	n of facilities	Mean Rate	Annual Rate change	CPI-U Medical Care Services
1995	538	$102.40		
1996	529	$105.78	3.30%	3.7%
1997	510	$109.53	3.54%	2.9%
1998	507	$114.92	4.93%	3.2%
1999	483	$118.72	3.31%	3.3%
2000	467	$123.83	4.30%	

Notes:
n of facilities is the number of facilities in the dataset; it is not the total number of facilities open in that year.
SAS reference: rsc.ltc.proc(mgwtrate)
casemix is based on management minutes categories (MMCs)

Source: Division of Health Care Finance and Policy

- Mean Medicaid rates have been increasing faster than health care expenditures nationally.
- Note that the CPI is a measure of the increase in prices to consumers, as opposed to an increase in the input prices faced by providers.

Figure 21:



	US	MA	CT	ME	NH	NJ	NY	PA	RI	VT
1995	$84	$101	$125	$106	$105	$102	$143	$96	$101	$94
1996	$88	$103	$126	$106	$104	$102	$157	$102	$102	$94
1997	$91	$112	$127	$113	$108	$112	$152	$109	$102	$100
1998	$96	$117	$134	$116	$115	$116	$159	$114	$104	$104
1999		$116		$116	$115		$174	$121	$112	$105

Source: State Data Book on Long Term Care Program and Market Characteristics

- Rates of increase in Massachusetts Medicaid per diem nursing facility rates are comparable to those in other states.
- Note that the services that are included in these rates vary from state to state. New York, for example, includes the widest range of ancillary services in its per diem rate of the states included here.

Ancillary Services Included in Medicaid Rate

	MA	CT	ME	NH	NJ	NY*	PA	RI	VT
dental						X			
durable medical equipment		X	X	X	X	X	X		
electrocardiology						X			
electroencephalogy						X			
hearing						X			
inhalation therapy									X
in-house medical supplies	X								
in-house physician services	X								
lab						X			
laundry								X	
medical supplies		X	X	X	X		X	X	X
non-precription drugs	X	X	X		X		X		X
occupational therapy				X		X	(as of 1/9	X	X
oxygen			X	X	X		X		X
patient transportation			X	X	X			X	
patient transportation (non-emergency only)							X		
physical therapy				X		X	(as of 1/9	X	X
physical therapy (maintenance only)		X							
physician services						X			
physician services (salaried or contracted only)							X		
podiatry						X			
psychiatric						X			
radiology						X			
respiratory therapy		X					X (as of 1/9	X	X
speech therapy									X
Total # of Ancillaries	**3**	**5**	**5**	**6**	**5**	**12**	**9**	**6**	**8**

* Non-prescription drugs, prescription drugs, medical supplies, patient transportation & speech therapy are all part of the direct component of NY's rate.

Source: State Data Book on Long Term Care Program and Market Characteristics

- Massachusetts Medicaid pays for this full range of ancillary services, but pays for most ancillaries separately, rather than in the per diem rate.

Notes on Division of Health Care Finance and Policy skilled nursing facility cost report data.

1. Only facilities that accept Medicaid are required to file cost reports with the Division. There are 40-50 nursing facilities in the Commonwealth that do not accept Medicaid, but may accept Medicare and therefore may be included in federal datasets.
2. Partial year cost reports, filed by new or closing facilities or by facilities that changed ownership, were excluded from the analyses in this report.
3. Because of the way the cost reports are structured, they do not provide any way to allocate total costs across payers. In addition, typical Medicare and private patients are in a nursing home for short-term intensive rehabilitation services, while typical Medicaid patients require less intensive chronic care over a period of years. However, it is extremely difficult to accurately measure the resource required by these different types of patients

Massachusetts Medicaid Skilled Nursing Facility Payment Methodology 1995-2000

Massachusetts pays nursing facilities a payment per day for Medicaid recipients in skilled nursing facilities. This payment covers routine room and board and daily nursing car
Additional ancillary expenses, such as physical or speech therapy, are paid separately.
The per day payment is split into component rates:

- *Nursing:* salaries and benefits for nursing personnel
- *Other Operating:* salaries and benefits for laundry, dietary, maintenance; also includes supplies, consultant fees, and administrative and general expenses
- *Capital:* annual depreciation expenses, interest and equity allowances, real estate taxes, and building insurance.
- *Transitional Payments:* These payments are made in order to facilitate the transition to a Standard Pricing System.

Year	General Description	Nursing Component	Other Operating Compon	Capital Component	Transitional Adjustments
199	Prospective Per Day Payme facility-specific costs from (“base year”), subject to cei	10 payment levels based on resident acuity, facility-spe subject to ceiling of median 3 geographic peer groups	Payment based on facility-s subject to various ceilings f administrative and variable geographic peer groups and groups for variable expense	Facility-specific payments depreciation, interest and e insurance	None.
199					
199					
199	Phase-in of Standard Paym System—Prospective Per D are based on a blend of faci costs and industry-wide pri	4 payment levels based on resident acuity; 33.3% Standard Rate 66.7% Facility-Specific Ra ceiling); no nursing payme be below 1997 levels.	Payment made on: 33% of Standard Rate 66.7% Facility-Specific Ra ceilings)	Facility-specific payments depreciation, interest and e insurance—based on 1993 $17.29 per day for new con on construc-tion cost index	No rate could be below 199 Rate increases capped at 9% levels.
199	Phase-in of Standard Paym System—Prospective Per D are based on a blend of faci costs and industry-wide pri	4 payment levels based on resident acuity: 33.3% Standard Rate 66.7% Facility-Specific Ra ceiling)	Payment made on: 33.3% of Standard Rate 66.7% Facility-Specific Ra ceilings)	Facility-specific payments depreciation, interest and e insurance—based on 1993 $17.29 per day for new con on construc-tion cost index	No rate could be below 199 Rate increases capped at 6% levels.

Year	General Description	Nursing Component	Other Operating Compon	Capital Component	Transitional Adjustments
20(	Phase-in of Standard Paym System—Prospective Per D are based on a blend of faci costs and industry-wide pri	6 payment levels based on i resident acuity: HIGHER OF 66.7% Standard Rate 33.3% Facility-Specific Ra ceiling) OR 50% Standard Rate 50% Facility-Specific Rate ceiling)	HIGHER OF 66.7% Standard Rate 33.3% Facility-Specific Ra ceilings) OR 50% Standard Rate 50% Facility-Specific Rate ceilings)	Facility-specific payments depreciation, taxes and insu Standard financing factor o assets for interest and equit 1998 base year; $17.29 per day for new con on construction cost index	No rate could be below 199 Rate increases capped at 6% levels. Additional $20 million paic on (post buffer)